DOCUMENT RESUME

ED 192 474 EC 130 126

AUTHOR	Gendreau, Joan C.; And Others
TITLE	Screening Manual: A Project APT Resource Manual.
INSTITUTION	Fairfax County Schools, Va.
SPONS AGENCY	Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE	80
CONTRACT	300-77-0256
NOTE	74p.; For related material, see EC 130 127-131.
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Auditory Tests; Behavior Rating Scales; Check Lists; Cognitive Tests; *Educational Diagnosis; Elementary Secondary Education; Family Environment; Individualized Education Programs; *Multiple Disabilities; Parent School Relationship; Physical Examinations; Resource Materials; *Screening Tests; *Severe Mental Retardation; Verbal Tests; Vision Tests
IDENTIFIERS	*Project APT

ABSTRACT

One of a series of materials developed by Project APT (Administrators, Parents, and Teachers/Assessment, Programing, and Training), a program designed to foster home/school coordination in educational planning and program implementation for severely mentally retarded and/or multiply handicapped students: the booklet provides five screening tools in the areas of hearing, vision, physical function (for both ambulatory and nonambulatory students), oral motor, and maladaptive behavior. For each of these areas, instructions for the use of the form, the actual form, and a statement of educational implications resulting from the screening are included. An introductory section outlines each screening instrument, surveys information needed in the assessment process, describes the intake procedure, and provides the screening summary form. Two other sections present a Cognition Checklist (for brief educational assessment) and a Home Information Questionnaire (which gathers information from parents). (PHR)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.

EC 130126

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Winna L. Vogel

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

SCREENING MANUAL

Project APT Staff:
Joan C. Gendreau, Project Director
Minna L. Vogel, Project Coordinator
Rona Leyman, R.P.T.
Gertrude C. Terman, O.T.R.
Lorraine Connors, Administrative Assistant
Robin Shadle, Design and Layout
Illustrations by Minna Vogel

1980
Department of Special Services
Fairfax County Public Schools
Fairfax, Virginia

TABLE OF CONTENTS

3 Introduction
4 Screening Descriptions
5 Summary Information
5 Intake Procedure
7 Screening Summary
11 Screening Profile

13 Hearing Screening
15 Instructions
17 Screening Form
18 Educational Implications

19 Vision Screening
21 Instructions
24 Screening Form
26 Educational Implications

27 Physical Function Screening
29 Instructions
31 Screening Form
34 Educational Implications

37 Physical Function Screening for Non-Ambulatory Students
37 Instructions
39 Screening Form
41 Educational Implications

43 Oral Motor Screening
45 Instructions
47 Eating Skills Matrix
48 Screening Form
50 Evaluation Forms
53 Educational Implications

55 Maladaptive Behavior Checklist
57 Instructions
58 Screening Form
60 Educational Implications
60 Levels of Intervention
62 Behavior Management Information Card
63 Initial Behavior Management Program Worksheet
64 Behavior Management Program Handling Orders

65 Cognition Checklist
67 Instructions
68 Screening Form

71 Home Information Questionnaire
73 Instructions
74 Screening Form A
77 Screening Form B

INFORMATION

Introduction

Project APT, funded through a three year contract by the Bureau of Education for the Handicapped in 1977, has been operating in Fairfax County Public Schools, Fairfax, Virginia. Utilizing a transdisciplinary team, Project APT is composed of a physical therapist, an occupational therapist, a special education teacher with background in behavior management, and an instructional aide. Project APT assists Administrators, Parents and Teachers of the severely mentally retarded in Assessment, Programming and Training. Facilitating an effective method for home-school coordination, Project APT has been instrumental in the development of more appropriate IEP's (Individualized Education Programs) for severely and multiply handicapped pupils.

In order to initiate a systematic procedure of educational planning and implementation, Project APT has developed a three-phase process of:

1. assessing to determine functional level of student ability through the use of an educational assessment, the Developmental Achievement Wheel
2. screening to determine areas of dysfunction
3. involving parents in the information-gathering process.

This booklet will deal with both the screening process and the involvement of parents in the gathering and sharing of information.

Five screenings are used to determine areas of dysfunction:
Hearing Screening
Vision Screening
Physical Function Screening
Oral Motor Screening
Maladaptive Behavior Checklist

In addition, there are two other forms, the Cognition Checklist, a very brief educational assessment, and the Home Information Questionnaire, an information form to be completed by the parents. The intent of these screening tools is simply to identify a need for further evaluation; they should not be considered diagnostic tools, nor should they take the place of more in-depth testing by skilled therapists.

All of the screenings were designed to be administered by the classroom teacher with input and assistance from therapists. The classroom teacher is urged to participate in these screenings for two reasons:

1. The classroom teacher knows the student more thoroughly than a visiting therapist and would be more likely to get good results.
2. The completed screening is generally better understood and more freely utilized for program adaptations when the classroom teacher has participated in the screening process.

Operating on the premise that parents are effective partners of school professionals, Project APT urges them to become involved in gathering information for home-school coordination. The Developmental Achievement Wheel and the Maladaptive Behavior Checklist, which are completed by both parents and classroom teachers, provide a basis for comparison of home-school functioning. The Home Information Questionnaire supplies current medical and family information relevant to the student's educational program. Parents who complete these forms give the school valuable information for educational planning.

Hearing and Vision Screenings

Both the hearing and vision screeings were developed in 1975, the result of years of observations. The fact that the typical audiometric and vision screenings did not provide sufficient information on severely, profoundly handicapped students had become increasingly apparent. Most of the students had been labeled "untestable" when the traditional screenings had been used.

The Hearing Screening is a general environmental assessment, giving the classroom teacher valuable information on the student's functional hearing ability and emphasizing localization and processing time.

The Vision Screening does not test visual acuity but rather how the eyes function individually and together. It is recommended that the N.Y. Lighthouse Screening be used for testing visual acuity.

Physical Function Screening

There are two versions of the Physical Function Screening—one for ambulatory students and one for non-ambulatory students. The first form was developed as an attempt to involve the classroom and/or physical education teachers in screening their students. It is not a checklist of gross motor skills, but rather it points out areas of dysfunction leading to poor gross motor ability. It also helps the teacher sharpen his or her observation skills and obtain a better understanding of the student's problems.

The items on the form for non-ambulatory students provide a brief assessment of the physically involved student's gross motor skills. This enables the teacher to quickly set up his or her program and to have needed equipment when the student enters the classroom.

Oral Motor Screening

This screening presents a checklist of oral motor skills pertaining to feeding and eating. With a high percentage of physically involved students, proper feeding may be a long, complicated, but extremely important, process. For the classroom teacher with several students who require one-to-one attention, this necessitates being extremely well organized. This means being aware of the student-staff ratio, necessary adaptive equipment, and appropriate feeding techniques. The Oral Motor Screening is an attempt to assist the classroom teacher in organizing the lunchtime program so as to be as effective as possible.

Maladaptive Behavior Checklist

Behavior, particularly "maladaptive" behavior, is not often discussed between staff and parents. However, with many severely, profoundly handicapped students, poor behavior impedes progress in other areas and needs to be considered. The Maladaptive Behavior Checklist is an observation checklist that is completed by both the staff and the parents. It can then be used as the basis for discussion and for planning a consistent behavior management program at school and home.

Cognition Checklist

The Cognition Checklist is not a screening to determine areas of dysfunction, but rather it is a brief educational assessment. By completing this when the student initially enters the school, the teacher obtains an estimate of the student's functional level, and is thus better able to plan the student's initial program. Most of the items in the Cognition Checklist are taken from the more complete assessment, the Developmental Achievement Wheel. The Cognition Checklist gives the teacher a head start towards the completion of that particular assessment.

Summary Information

In order to best utilize the information gathered from the assessment process, the teacher may find it helpful to summarize the data on the forms included in this section.

The first form is a folder which covers two major areas: (1) **Screening Summary** allows the teacher to note the results of all the screenings and indicate the need for follow-up in any major area. (2) **Medical Information** is obtained from the student's cumulative folder and updated yearly as necessary.

The second form, the **Screening Profile**, serves as a staffing agenda for the interdisciplinary team. The initial sections of this form summarize current educational status and graph the student's degree of dysfunction in each of the screening areas. This information, coupled with the teacher's and therapists' observations, is then used as a basis for program planning. Section IV presents a continuum of cognitive development which defines a starting point for teaching concepts. The levels of operation outlined in this section of the form are defined as follows:

Real Objects: At this stage, the student relates only to actual experiences or full-size objects.

Concrete Representations: The student comprehends toys and three-dimensional realistic objects as representations of real objects, e.g., toy car, stuffed duck.

Realistic Pictures to Abstract Pictures: Here, the student must construct a link between the real object and the representation of it in a picture. The increased sophistication of the student is demonstrated as he or she moves from pictures which are realistic (photographs) to those which are more abstract (line drawings).

Symbolic Representations: On the symbolic level, the student may demonstrate skills in varying degrees of sophistication in visual, auditory, and motoric channels: (1) receptively understanding verbal concepts and demonstrating that understanding in a motor activity, e.g., following the direction "Go *down* the slide"; (2) translating a visual symbol into its conceptual meaning, e.g., traffic light with colors; (3) responding to written symbols and demonstrating an understanding of the meaning of the written word.

The process of individualizing a student's educational program is in part based on his or her own strengths and weaknesses. Section V offers a checklist for individual abilities in input and output.

Section VI is another continuum highlighting degree of ability in self-help and daily living skills.

In utilizing this profile as a staffing agenda, the interdisciplinary team may generate concerns and recommendations which can then be recorded on the bottom of the form.

The Intake Procedure

State regulations require that a student have a signed IEP before entering a public school special education program. In order to make this more than a mere formality, Project APT, using the screenings it has developed, has devised an initial intake procedure to gather five kinds of information:

1. More useful classroom information for program planning
2. Pertinent home information for use in home-school coordination of educational plan
3. Information on areas of dysfunction for possible medical referral
4. Information an areas of dysfunction which may require further evaluation by specific therapists (occupational therapy, physical therapy, speech and language, vision and hearing consultants)
5. Initial assessment data for the development of a meaningful IEP

The initial intake and the IEP conference are held within thirty days of the eligibility meeting and follow a three-step process:

1. Preparation for the Conference

In this preliminary phase, the initial conference is scheduled, and parents receive a letter confirming the appointment and explaining the procedure. They also receive a home information questionnaire designed to gather useful home data and eliminate repetitious forms and discussions.

During this time, the staff familiarize themselves with the packet of materials from the eligibility committee meeting.

2. Initial Conference

Project APT and appropriate school staff administer screenings to the student while the parents tour the school with the social worker and discuss medical history with the nurse. The screenings include Hearing, Vision, Physical Function, Oral Motor, and the Cognition Checklist. The Maladaptive Behavior Checklist is completed after the student is in school. This information is then transferred to the Screening Profile.

The staff and parents meet to:

a. Share screening results and their educational implications
b. Discuss parent questionnaire information and concerns
c. Decide on three initial goals and what further evaluations are to be recommended
d. Complete initial IEP forms

3. Thirty-day Conference

Held thirty days after the initial IEP meeting, this conference is for the teachers and specialists to present a more thorough picture of the school program. This review is not mandated by state law, but has been found to be an effective way to continue developing home-school coordination.

The initial intake procedure has been shown to provide useful information for developing an appropriate IEP and initiates parent-teacher communication. The thirty day follow-up procedure provides an opportunity for continuation of this rapport as well as a forum for sharing in-depth assessment information and ideas for program planning.

SCREENING SUMMARY

Pupil: _____

DOB: _____

Center: _____

Date: _____

Case Manager: _____

MEDICAL INFORMATION

Diagnosis: (e.g., CP, MR, profound hearing loss, behavior problems, etc.):

Physicians currently seeing child (including all specialists):

Surgery (type and date):

Physician-prescribed treatment (i.e., ear tubes, therapy, etc.):

Assistive devices (glasses, braces, hearing aids, etc.):

Related professional services (speech, hearing, vision specialists, O.T., P.T.) received outside school:

Physician-prescribed medication and date prescribed:

Allergies;

Seizures:

Physician-prescribed restrictions:

Other medical precautions:

SCREENING SUMMARY

	Hearing	Vision	Physical Function	Oral Motor	Maladaptive Behavior
No apparent problem evident from screening results.					
Needs to be rescreened; results are presently inconclusive.					
Problem present. Needs consideration in program development and selection of goals and/or classroom modifications.					
Recommend further in-house evaluation, i.e., P.T., O.T., and/or behavior management mtg.					
Recommend further evaluation by county specialists, i.e., vision, hearing consultants.					
Recommend referral to medical professional.					
Other, specify.					

Check appropriate box in each column.
(See back cover)

UPDATE

SCREENER	DATE	SCREENING	INFORMATION

Pupil _____ Date _____
D.O.B. _____ Screener _____
Age _____ _____

Screening Profile

I. General Information

Diagnosis:

Background Information:

Medical Information:

II. Current Level of Functioning

DAW, AAMD, any other educational assessment data:

Psychological Information:

III. Areas of Dysfunction

Level of Dysfunction	Hearing	Vision	Physical Function	Oral Motor	Maladaptive Behavior
1. Profound—dysfunction present to such a degree that it requires alternative strategies for instruction, management and/or maintenance.					
2. Severe—dysfunction present requiring ancillary services.					
3. Moderate—dysfunction present and needs classroom adaptation.					
4. Mild—dysfunction present but non-interfering.					
5. Within Normal Limits.					

**Put a dot at the appropriate intersecting point for each screening.
**Draw a solid line to connect the dots.

IV. Cognitive Development Continuum

Real Objects	Concrete Representations	Realistic Pictures	Abstract Pictures	Symbolic Representations

V. Summary of Student's Strengths and Weaknesses

Strongest Channel of Input:
Auditory _____ Visual _____ Tactile/Kinesthetic _____

Strongest Channel of Output:
Verbal _____ Visual _____ Motor _____

Weakest Channel of Input:
Auditory _____ Visual _____ Tactile/Kinesthetic _____

Weakest Channel of Output:
Verbal _____ Visual _____ Motor _____

Behavior Management Observations:

Comments:

VI. Dependent/Independent Continuum

Is Totally Dependent	Has Self Care Skills	Has Daily Living Skills	Has Workshop Skills	Is Totally Independent

VII. Transdisciplinary Concerns and Recommendations

Number	Concern	Recommendations	Agent

Staff Present:

HEARING

13

Instructions for Hearing Screening

This screening tool is designed to assist in identifying those pupils who may need referral for additional evaluation. It is not intended as a diagnostic instrument.

Items presented during the screening were chosen to encompass the two categories of sounds heard in the classroom—the human voice and some typical environmental sounds made by sound-producing objects. Some pupils respond more readily to the voice than to the bell or drum; with other pupils the reverse is true.

Materials

1. 8" drum and mallet
2. 3" diameter bell
3. one favorite sound toy (optional)
4. cloth screen
5. two tapes with marks at 3′ and 15′
6. two chairs of appropriate size for pupil
7. screening forms
8. pencil

Screening Team

The screening team includes a screener and an assistant.

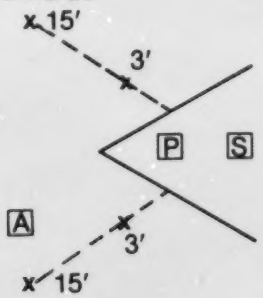
1. The screener:
   a) directs the pupil's behavior, preparing him or her for the sound presentations
   b) directs the assistant to present the sound stimuli
   c) records the pupil's responses

Note: It is important that the recorder have normal hearing in both ears in order that he or she may localize the sound to score correctly or determine if the sound is not definitive enough for the pupil to judge.

2. The assistant:
   produces the sound stimulus

Setup

[P] pupil
[S] screener
[A] assistant



Place the two chairs inside the screen, facing each other. Attach a 15′ tape to the middle of each side of the outside of the screen. Make sure to position the screen so you will have enough room to stretch the tape out to 15′ at approximately a right angle to the screen.

Procedure

The pupil is taken directly to the chair, told to sit down, to look at the screener, and to listen. The cue word "ready" may be used to alert the assistant to begin sound presentation.

The screening assistant begins with localization of voice at 3′. The choice of left or right presentation is at his or her discretion so that each stimulus is random in nature. It is important that the recorder monitor the sound for localization auditorily, watching the pupil at all times to avoid giving cues with his or her eyes. If the pupil does not respond at 3′, do not continue to test at 15′. Do not increase loudness of stimulus when changing distances. All items should be presented out of sight of pupil (behind screen, etc.) to minimize visual cues.

A normal tone and volume are used. The assistant's words may vary, but in general the pupil's name followed by a simple command ("Jeanie, come, Jeanie, find me") will elicit a response. Some typical responses might include:

1. widening of eyes
2. quiet, listening attitude
3. eyes looking toward sound
4. turning of head
5. walking to sound source
6. pointing
7. verbal response

If the pupil fails to respond or responds inappropriately, record what you have observed. Items may be repeated three or four times to elicit an observable response. If the pupil's behavior does not appear related to a hearing problem, indicate this and describe the behavior. If a corrective device is in use, screen first without, and then with, correction.

The pupil's reaction should be scored as follows:

+ in localization column if pupil localizes correctly
– in localization column if pupil appears to hear sound but cannot localize
+ in response column if pupil appears to hear sound but cannot localize
– in response column if no response is noted

After each correct response the assistant may appear or stimulus may be presented momentarily to the pupil for reinforcement. The same procedure is used for the 15′ distance.

Whisper localization follows the same procedure as voice localization. Use a projected whisper and avoid voice quality.

In localizing the bell or drum, the screener directs the pupil with a simple command such as: "Jeanie, look for the drum," "Jeanie, find the bell." Immediately after the command is given, the assistant produces the stimulus.

If the response to a given item is questionable, you may go back and retest.

Under comments, indicate the types of responses that are elicited with various stimuli, e.g., actual identification and discrimination, startle, blink, etc. Finally, fill in your results and recommendations on the hearing section of the Screening Summary Form.

If pupil can be conditioned to respond and indicate consistently when he or she hears, other standardized audiometric screening and testing should be considered.

Sample Screening Form

	Left Ear		Right Ear		
Stimulus	Response	Localization	Response	Localization	Comments
Voice at 3′					
Voice at 15′					
Whisper at 3′					
Whisper at 15′					
Bell at 3′					
Bell at 15′					
Drum at 3′					
Drum at 15′					
Other at 3′ ( )					
Other at 15′ ( )					

Pupil _____ Homeroom Teacher _____
D.O.B. _____ Date _____
Center _____ Screened by _____

Hearing Screening

Physical Observation

Outer ear: ☐ Normal ☐ Abnormal (describe)_____
Ear canal: ☐ Open ☐ Closed ☐ Wax present ☐ Drainage ☐ Redness (irritation)

Materials and Screening Team Needed

1. 8" drum and mallet
2. 3" diameter bell
3. one favorite sound toy (optional)
4. cloth screen
5. two tapes with marks at 3' and 15'
6. two chairs of appropriate size for pupil
7. screening forms
8. pencil
9. recorder
10. assistant

Administration and Scoring

Present items in prescribed order, out of sight of pupil, who is seated behind screen facing recorder. Present each stimulus first at three feet, then at fifteen feet, maintaining the same level of intensity.

If the pupil localizes sound correctly, place a + in the localization column. If the pupil appears to hear the sound, but cannot localize correctly, place a – in the localization column and a + in the response column. If no response is noted, place a – in the response column.

	Left Ear		Right Ear		
Stimulus	Response	Localization	Response	Localization	Comments
Voice at 3'					
Voice at 15'					
Whisper at 3'					
Whisper at 15'					
Bell at 3'					
Bell at 15'					
Drum at 3'					
Drum at 15'					
Other at 3' ( )					
Other at 15' ( )					

Educational Implications

When a child is identified by this screening as having a potential hearing problem, the teacher can often glean pertinent information by talking with the parent about past medical history. For some children with chronic ear infections, the results of the screening may vary according to middle ear involvement. This sharing of home-school information will allow the teacher to make a knowledgeable referral to the local hearing specialist, audiologist, or appropriate doctor. This follow-up evaluation may help to determine specific needs and adaptations.

The following suggestions may offer teachers practical assistance in working most effectively with any youngster having a suspected hearing difficulty.

- Be aware of the auditory environment in the classroom. Make sure it is not so overwhelming to the student that he or she cannot begin to sort out the multitude of auditory stimuli.

- Determine through observation whether the child's lack of response to auditory input is a matter of actual hearing acuity or slow/inefficient auditory processing skills. We have all seen the child who shows a marked delay between hearing a verbal direction and actually carrying out the task. Again, reducing the amount of auditory distraction or altering the environment may contribute to the success of the child's performance.

- Consider placement of the child in the classroom. It is probably most effective to place the child close to the sound source for maximum reception. Do not place student in room near windows or doors because this not only distracts the pupil but also makes it difficult for him or her to hear.

- Make sure that when giving verbal direction, you are on the same physical level as the student. This allows the student to more easily cue in to facial expression, lip reading, and gestural expression.

- Be constantly aware of your own position in the classroom relative to the student:
  - — Face the child at all times when giving directions.
  - — Position student so his or her back is to the light and you are facing its source if light is creating a glare.

- In order to facilitate language development, use short, simple sentences rather than long, strung-out sets of directions. Talk to the student even if you do not feel he or she can hear you. This will help exercise the residual hearing the student may have. Even if he or she cannot hear your words, he or she can see what you are saying. If you wear lipstick, it is easier for the student to read your lips. Never shout at the student in an attempt to increase audibility, or exaggerate lip movements—this typically will make the sounds only more confusing and will become frustrating and embarrassing to both student and teacher.

- Couple gestures and signs with spoken language as this not only will increase the student's receptive ability but may also help to build the student's gestural and verbal expressive skills.

- Provide the student with clear visual and tactile props as key channels for learning. Build on the student's strongest areas of input and output.

- Consider grouping students with hearing difficulties together for certain activities for effective classroom management.

- Check the working order of a student's hearing aid each day to maximize learning benefit. Teach the child to wear the hearing aid properly and to treat it with respect.

VISION

19

Instructions for Vision Screening

This screening tool is designed to assist in identifying those pupils who may need referral for additional evaluation. It is not intended as a diagnostic instrument or a test for visual acuity. The screening attemps to assess the pupil's ability to use the small muscles of the eyes in a smooth, coordinated manner.

Occluding vision to test eyes individually may produce irritable behavior or even acute anxiety. If this occurs, do not force the pupil to accept an eye patch, but plan to rescreen later. In the interim, the classroom teacher can help the pupil become accustomed to having one eye occluded as well as improving tolerance to touch around the face.

Materials

1. two penlights
2. lollipop, coke, or favorite food (if pupil fails to respond to the penlight any of these stimuli may be used)
3. whiffle ball with string attached
4. spinning toy
5. eye patch and/or cloth drape or adapted glasses
6. three chairs of appropriate size for pupil
7. screening forms
8. pencils
9. N.Y. Lighthouse Vision Screening (as appropriate)

Screening Team

The screening team includes a screener, a recorder, and an assistant when needed (if possible).

1. The *screener:*
   a) presents the stimuli
   b) maintains pupil's level of interest
   c) observes pupil's responses

2. The *recorder:*
   records data and pupil's behaviors

3. The *assistant:* (if possible)
   produces stimuli for peripheral vision and blink reflex

Setup

Pupil Screener Recorder Assistant (if possible)

Administration

Administer the screening in a quiet room that can be darkened. If necessary, a screen may be used to eliminate distractions within the room. (The very young severely involved pupil may be adequately screened while positioned on a mat.)

Scoring

Place + in appropriate column for correct response, – for poor response. If the pupil fails to respond or responds inappropriately, record what you have observed. Items may be repeated three or four times to elicit an observable response.

Procedure

As the pupil enters, he or she is told to "sit down in the chair and look". The screener begins by checking the following:

1. Pupillary Reaction: The penlight is held 12" in front of the pupil's eyes. The light is flashed directly into the eyes, then away. Pupil dilation and contraction are noted.

Light causes pupil to contract:

Darkness causes pupil to dilate:

The screener checks both eyes together by flashing the light in front of the bridge of the nose, then right, then left. If the student's pupils dilate and contract, score a plus in the proper box. If you have a question, score a minus. The screener conveys data to the recorder by saying "positive" for plus and "negative" for minus.

2. Muscle Balance: Again the screener holds the penlight 12" from the pupil's eyes at midline. The light should reflect on the student's pupils if there are no muscle problems. If it is possible to see the light reflected in the center of one pupil and not in the center of the other, this indicates an imbalance and is scored as such.

3. Convergence: Check convergence by moving the penlight from the 12" point toward the bridge of the pupil's nose. The eyes should follow the light to approximately 2" from the bridge of the nose.

4. Tracking: Check horizontal, vertical, right and left oblique on both eyes simultaneously before obscuring the vision of one eye with a patch or drape. Covering one eye can elicit interfering behaviors in some pupils. Left oblique is to the pupil's left; right oblique is to the pupil's right.

5. Peripheral Vision: The recorder or assistant stands behind pupil, turns on the penlight, and brings the light around the side of the pupil's head at a distance of 12". The recorder brings the light forward until the pupil responds by looking at the light. The pupil has adequate peripheral vision if he or she responds by looking at the stimulus as it appears alongside the face.

6. Blink Reflex: The screener says, "Sheila, look at me" and the recorder or assistant produces the blink stimulus. (Whiffle ball on a string is dropped from behind, without pupil's prior knowledge, to within 2" of face.) For the young involved pupil lying on a mat, a quick movement of the screener's hand toward the pupil's face will elicit a blink.

7. Distance Vision:
   a) The screener walks away 10' and calls, "Sheila, look at me." The next direction is "watch me." The screener walks across the field of vision at 10'.
   b) For those pupils whose fixation is questionable, the examiner should activate a spinning toy 10' away from pupil. The pupil should visually fixate on the object while it spins.

If the response to any given item is questionable, you may go back and retest.

Under "Comments", you may include any behavioral descriptions as well as any difficulties with the individual items.

Sample Screening Form

	Both	Right	Left	Comments
1. Pupillary Reaction (12″)				
2. Muscle Balance (12″)				
3. Convergence (12″)				
4. Can Track at 12″:				
a) Horizontally →				
b) Vertically ↓				
c) Left Oblique ↘				
d) Right Oblique ↙				
5. Peripheral Field (12″)				
6. Blink Reflex				

7. Distance Vision:

Can localize familiar people at 10′ ☐ Yes ☐ No

Can track familiar people at 10′ ☐ Yes ☐ No

or

Can fixate on a spinning object at 10′ ☐ Yes ☐ No

Screening for Visual Acuity

For those pupils who are able to cooperate with further vision screening, administer the N.Y. Lighthouse Vision Screening to determine visual acuity. This may be obtained from:

The Lighthouse Low Vision Services
111 East 59 Street
New York, N.Y. 10022

Administration

Present the "200" cards at 5′. If responses are correct, present the "200" cards at 10′. At this distance, present the "100," "50," "40," and "20" cards. The test may be completed at 10′ by showing the "10" card. This produces the same result as showing the "20" card at 20′.

The test may also be done at the conventional 20′ range. However, interest and participation may be higher when both the examiner and the cards are at 10′.

Scoring

If the response is correct, place a + in the appropriate column on scoring sheet. If response is incorrect, place a −.

To determine visual acuity, divide the distance at which all three symbols have been identified by the smallest size of card that was correctly identified, e.g., at 10′, the "100" cards were correctly identified. The acuity would then be 10/100 or converted to standard symbols, 20/200.

Pupil _____
D.O.B. _____
Center _____

Homeroom Teacher _____
Date _____
Screened by _____
_____
_____

Vision Screening

Physical Observation

_____ Size or shape difference in pupils
_____ Excessive tearing
_____ Cloudiness
_____ Eyes not aligned properly (describe)
_____ Squinting
_____ Blinking
_____ Inflammation or redness
_____ Other (describe)

Materials and Screening Team Needed

1. two penlights
2. lollipop, coke or favorite food (if pupil fails to respond to the penlight any of these stimuli may be used)
3. whiffle ball with string attached
4. spinning toy
5. eye patch and/or cloth drape or adapted glasses
6. three chairs of appropriate size for pupil
7. screening forms
8. pencils
9. N.Y. Lighthouse Vision Screening (as appropriate)
10. screener
11. recorder
12. assistant (if possible)

Administration and Scoring

Place a + in appropriate column for correct response, a – for poor response. If the pupil fails to respond or responds inappropriately, record what you have observed. Items may be repeated three or four times to elicit an observable response.

	Both	Right	Left	Comments
1. Pupillary Reaction (12″)				
2. Muscle Balance (12″)				
3. Convergence (12″)				
4. Can Track at 12″: a) Horizontally →				
b) Vertically ↓				
c) Left Oblique ↘				
d) Right Oblique ↙				
5. Peripheral Field (12″)				
6. Blink Reflex				

7. Distance Vision:
   Can localize familiar people at 10′ ☐ Yes ☐ No
   Can track familiar people at 10′ ☐ Yes ☐ No
   or
   Can fixate on a spinning object at 10′ ☐ Yes ☐ No

Pupil _____
D.O.B. _____
Center _____

Homeroom Teacher _____
Date _____
Screened by _____

N.Y. Lighthouse Vision Screening

Distance from Pupil / Size & Type of Card	"200" House	"200" Apple	"200" Umbrella	"100" House	"100" Apple	"100" Umbrella	"50" House	"50" Apple	"50" Umbrella	"40" House	"40" Apple	"40" Umbrella	"20" House	"20" Apple	"20" Umbrella	"10" House	"10" Apple	"10" Umbrella
5′																		
10′																		
20′																		

If response is correct, place a + in the appropriate column on scoring sheet.
If response is incorrect, place a – in the appropriate column on scoring sheet.

Comments:

25 Visual Acuity _____

26

NOTE:
This form was developed by Project APT for use with the N.Y. Lighthouse Vision Screening.

27

Educational Implications

Students who have been identified as having a possible vision problem following this screening, or who have been enrolled in school with a diagnosed visual impairment, should be referred to vision specialists within the school system. If such specialists are not available, regional consultants of the state Commission for the Visually Handicapped can be called upon for assistance. Some parents may require the teacher's help in locating a doctor who specializes in pediatric ophthalmology.

The classroom for students who are visually or perceptually impaired must be well-organized and sparsely furnished with a minimum of decoration. A room can be pleasant with a limited number of thoughtfully selected bright objects. When every square inch of wall is covered with busy pictures, charts, and learning devices, the visually involved pupil may have difficulty attending to the task at hand.

In like manner, work must be presented to the student on a work surface cleared of all other materials. If necessary, a carrel can be used to provide additional screening of distracting stimuli. Many pupils will require visual rest because perceptually or visually impaired students tire easily when working at table activities. Rest may involve a complete cessation of activities, or it may mean a change of pace, as indicated. The teacher can introduce an activity which involves the whole class so that the students use their distance vision for a brief period.

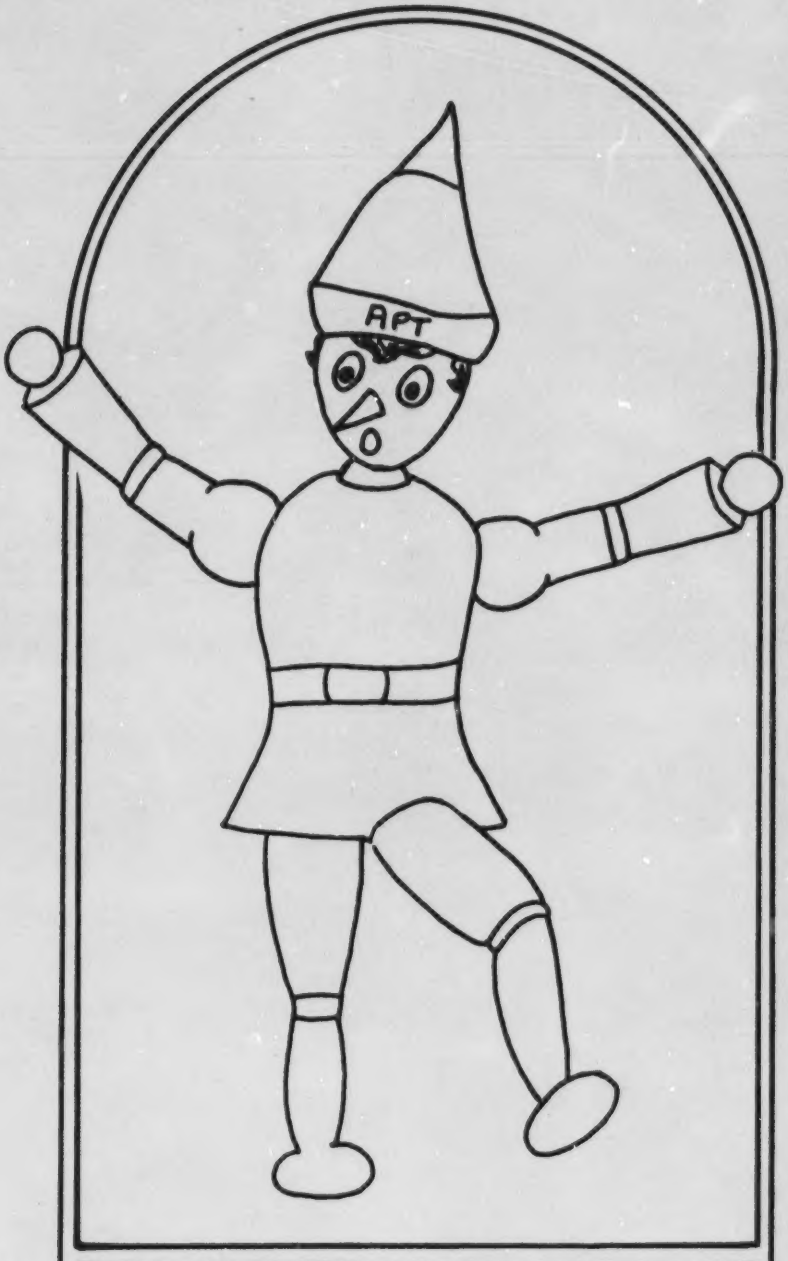
The direction and quality of the lighting are most important. Glare from windows can be most irritating. Placing students so that their backs are to the windows can be a simple way to remove this stimulus.

Some pupils can function with more efficiency if classwork is placed on a table easel rather than flat on the table or desk. Others work more happily if work is oriented to the stronger field of vision. In some instances, students are more comfortable if work is oriented "top to bottom" rather than "left to right". The teacher must be aware that a small percentage of pupils may use their peripheral vision for table activities. The clue to watch for is a cocking of the head, as the pupil assesses the task at hand, then looks into the middle distance as he or she performs the necessary manipulations.

Tracking activities may greatly enhance the pupil's performance of eye-hand classroom activities and can also provide a change of pace because most tracking activities can easily be converted to games.

Many of the most important classroom implications occur in the gross motor area. For the physically handicapped student, proper positioning is a basic prerequisite for optimum performance of visually related activities. A physical or occupational therapist can provide the teacher with invaluable assistance because a comfortable, well-positioned pupil can be more productive.

Ambulatory students' gross motor performance can be affected by visual deficits also. Depth perception problems can make movement throughout the school and playground an obstacle course for these children. Slow responses to directions may be easily explained when one realizes that each visual misinterpretation may make a crevice out of a crack in the floor, or that an apparent change in elevation occurs when the floor tiles change color. Carefully graded obstacle courses with vestibular activities may help the student improve his or her sense of security when moving through the world.



PHYSICAL FUNCTION

27

Instructions for Physical Function Screening

This screening tool is designed to assist in identifying those pupils who may need referral for additional evaluation by a physical or occupational therapist. It is not a skills inventory for the area of gross motor but is a method for identifying possible postural deformities, orthopedic problems, and central nervous system deficits. It is not intended as a diagnostic instrument or as a replacement for more in-depth physical and occupational therapy evaluations.

Some pupils may object to being touched or handled. Since this screening requires some hands-on activity from the screener as well as cooperation from the pupil, it is wise not to insist on completing those items which are upsetting to the pupil. Instead, note the behaviors on the recording sheet and plan to rescreen at a later date. Removing shoes and socks may also be a problem for those pupils who cannot tolerate walking barefoot, particularly on carpeting. Again, do not insist on removal of shoes and socks; note the behaviors on the recording sheet and go on to more pleasant items.

The Physical Function Screening consists of two forms (choose the appropriate one for your pupil):

1. Physical Function Screening
2. Physical Function Screening for Non-Ambulatory Pupils (or pupils requiring adaptive equipment for ambulation)

Materials

1. two small balls, one on a string
2. three small items for checking grasp
3. mat (if possible)
4. two sets of screening forms, one for screener, one for recorder
5. pencils

Screening Team

The screening team includes a screener and a recorder.

1. The *screener:*
   a) directs pupil in appropriate activity
   b) observes responses
   c) instructs recorder

2. The *recorder:*
   a) records data according to screener's observations
   b) records pupil's behaviors

Setup

Administer the screening in a quiet room that is free from as many distractions as possible. If a mat is available, it should be used in order to maintain good hygiene and may make those items requiring balance on knees or hands and knees more comfortable. If a mat is not available, try to find an area with a relatively clean floor.

Administration

Posture: These items require only observation. If the pupil is wearing several layers of clothing, e.g., a bulky sweater or jacket over a shirt, you may want to remove some of the outer clothing. If pants are worn, you may ask the pupil to roll them up over the knees. If this is objectionable to the pupil, do not insist. He or she should not be made to feel embarrassed or uncomfortable.

Observe each of the items listed on the form and check the appropriate lines. Observation is a very sophisticated skill and at the beginning you may not see as much as someone with a practiced eye. However, the more often you look, the more you will be able to see.

Balance: These two items are self-explanatory. The pupil cannot hold on to an object for either item and may resist if he or she suspects it is too difficult. This may tell you something about both skill level and cognitive awareness.

Reflexes: These items are aimed at identifying an immature central nervous system or one that is not fully integrated. They are by no means conclusive, but when combined with other symptoms, e.g., perceptual problems or clumsiness, may indicate a need for further evaluation by an occupational or physical therapist. All items are done in the quadriped or hands and knees position.

Testing for Symmetrical Tonic Neck Reflex (STNR): Pupil looks up toward the ceiling and arms automatically straighten (increase in extension):

Pupil looks down toward floor and arms automatically bend (increase in flexion):

Testing for Asymmetrical Tonic Neck Reflex (ATNR): Pupil looks down toward floor and turns head to right causing left shoulder to dip and left elbow to bend. This is reversed when pupil turns head to opposite side:

Shoulder Stability: This item is performed in the extended-arms position. Look for the pupil who has to consciously shift his or her weight over to one side before he or she can reach with the opposite arm. Notice differences between sides and those pupils who are unable to accomplish this activity at all.

Two-Hand Use: This item can be used as a break time if the pupil likes to play ball. However, it is not a break for the screener who should be constantly observing.

Eye-Hand Coordination: Swing the ball in all directions and check both hands. Attempt to get pupil to cross midline in either direction.

Dominance and Grasp: Note the most sophisticated grasp the pupil uses. You may try a variety of objects, e.g., small candies, pennies, pellets. Also note from this item and your observations during the entire screening whether the pupil seems to use a preferred hand.

Wrist Rotation: Elbows must be kept at the side to avoid any shoulder movement. Note any discrepancies between sides, e.g., right hand turns up more than left.

Imitation of Movement: This item may be scored as passed whether the pupil duplicates the screener's position or mirrors it (pupil extends left arm when screener extends right arm). Also note that pupils who attempt the item and manage to get their arms in the general direction but are not quite precise.

Tolerance to Handling: This item should be marked as a result of observations during the screening. Many pupils enjoy physical contact while others prefer to keep some distance between themselves and another individual.

Pupil _____
D.O.B. _____
Center _____

Homeroom Teacher _____
Date _____
Screened by _____
_____
_____
_____

Physical Function Screening

Materials and Screening Team Needed

1. two small balls, one on a string
2. three small items for checking grasp
3. mat (if possible)
4. two sets of screening forms
5. pencil
6. screener
7. recorder

Administration

Check those items which apply.

Posture—Static and Dynamic

Remove pupil's shoes and socks

Observe pupil while he or she is *standing* with *shoes off:*

Head

- ☐ Within normal limits
- ☐ Forward
- ☐ Back
- ☐ To right side
- ☐ To left side

Shoulders

- ☐ Within normal limits
- ☐ Right higher than left
- ☐ Left higher than right
- ☐ Elevated
- ☐ Rounded forward
- ☐ Pulled back

Spine

- ☐ Within normal limits
- ☐ Scoliosis—C or S curve to right or left
- ☐ Kyphosis—excessive roundness of upper back
- ☐ Lordosis—excessive concavity of lower back

Arms

- ☐ Within normal limits
- ☐ Held rigid at side
- ☐ Flexed
- ☐ Different posture from one side to the other

Hips

- ☐ Within normal limits
- ☐ Flexed
- ☐ Different posture from one side to the other

Knees

- ☐ Within normal limits
- ☐ Flexed
- ☐ Hyperextended
- ☐ Knock-kneed
- ☐ Bowed legs
- ☐ Different posture from one side to the other

Ankles

- ☐ Within normal limits
- ☐ Rolled inward
- ☐ Rolled outward

Feet

- ☐ Within normal limits
- ☐ Turned in
- ☐ Turned out

Observe pupil while he or she is *walking* with *shoes and socks off:*

Arms

- ☐ Within normal limits
- ☐ Arm swing and posture different from one side to the other
- ☐ Other (describe)
- ☐ Hands held stiffly at sides
- ☐ Hands held shoulder high, elbows bent

Ankles

- ☐ Within normal limits
- ☐ Rolled inward
- ☐ Rolled outward

Feet

- ☐ Within normal limits
- ☐ Turned in
- ☐ Turned out
- ☐ Flat footed gait
- ☐ Wide stance (waddle)
- ☐ Limps
- ☐ Tiptoes

Shoes (Type of shoe:_____)
Examine for wear:

- ☐ Outside
- ☐ Inside
- ☐ Equal wear
- ☐ Scuffed toes
- ☐ Uneven wear
- ☐ New shoes with no apparent wear

Pupil may put shoes and socks on.
Observe pupil while he or she is *walking* with shoes and socks on.
Pupil walks better with:

- ☐ Shoes on
- ☐ Shoes off
- ☐ Both the same

Balance

Pupil maintains balance on each foot for: ___ seconds right foot ___ seconds left foot.

Observe pupil while he or she is *kneeling* on mat:

Pupil maintains balance when he or she is gently pushed at the shoulders to the right, left, front, and back.
Pupil loses balance to:

- ☐ Right side
- ☐ Left side
- ☐ Forward
- ☐ Back
- ☐ Maintains balance in all directions
- ☐ Cannot (will not) assume position

Reflexes

Observe pupil while he or she is in *hands and knees* position:

Pupil looks *up* toward ceiling:

- ☐ Arms remain the same
- ☐ Arms increase in extension (straighten)

Pupil looks *down* toward floor:

- ☐ Arms remain the same
- ☐ Arms increase in flexion (bend)

Pupil looks *down* toward floor and turns *head* to his or her *right:*

- ☐ Arms remain the same
- ☐ Left shoulder dips and left arm increases in flexion (bends)

Pupil looks *down* toward floor and turns *head* to his or her *left:*

- ☐ Arms remain the same
- ☐ Right shoulder dips and right arm increases in flexion (bends)

Shoulder Stability

From hands and knees position, pupil extends legs, so that weight is shifted to hands, abdomen, and legs.

Pupil reaches forward with either hand:

- ☐ Can reach with either hand easily
- ☐ Can reach with either hand with difficulty
- ☐ One side is easier than the other
- ☐ Cannot reach with right hand
- ☐ Cannot reach with left hand

Observe pupil while he or she is *sitting* on floor:

Two-Hand Use

A small ball is thrown to pupil who is encouraged to throw it back using both hands:

- ☐ Uses both hands equally
- ☐ Right hand lags
- ☐ Left hand lags

Eye-Hand Coordination

A small ball on a string is swung in front of the pupil who is encouraged to catch it with either hand:

- ☐ Is accurate with either hand
- ☐ Right hand is inaccurate
- ☐ Left hand is inaccurate
- ☐ Crosses midline to stop ball

Dominance and Grasp

Three small items are placed at midline. Note hand used for retrieval and type of grasp (3X):

- ☐ Rake to retrieve
- ☐ Thumb and side of index finger
- ☐ Little finger and thumb grasp
- ☐ Pincer (thumb and index in opposition)
- ☐ Other

Preferred hand:

- ☐ Right ☐ Left
- ☐ Shows no preference

Wrist Rotation

With elbows at side, pupil is asked to turn hands with palms facing up:

- ☐ Can turn both hands up
- ☐ Cannot turn right hand up
- ☐ Cannot turn left hand up

Imitation of Movement

Screener demonstrates the following movements:

1.
2.
3.
4.

Pupil fails to imitate:

☐ #1 ☐ #2 ☐ #3 ☐ #4 ☐ Able to do all 4

Tolerance to Handling

- ☐ Pupil does not object to being touched
- ☐ Pupil objects to being touched

Comments:

Educational Implications

Postural deformities, central nervous system deficits, and orthopedic problems affect more than just a student's ability to perform gross motor skills. Listed below are some of the educational implications to consider in classroom programming.

1. Poor posture may be directly related to a lack of ability in the performance of motor skills. In addition, it may also affect a student's ability to sit comfortably in a standard chair and attend to a task. Poor balance, muscle weakness, and small stature also play a role in the student's performance of educational tasks. If he or she is physically uncomfortable, needs to hold on to the desk or chair for stability, or cannot reach the floor with his or her feet, the student will not be able to give his or her full attention to the task at hand. Once this problem is noted, the teacher should consult with the physical therapist or occupational therapist to provide the student with more appropriate seating.

2. Many students are viewed as having behavior problems because they refuse to participate in physical education or cannot remain seated for prolonged periods of time. With some of these students, the basic problem is not behavioral, but an inability to perform motor tasks or to sit comfortably in their seats. These students could greatly benefit from some remedial help (adaptive physical education, physical therapy, or occupational therapy) and increased understanding of the problem on the part of the teacher.

3. As a result of this screening, you may notice some students who react negatively to being touched. This reaction may also be carried over into the classroom, where the student has been considered to be a behavior problem because he or she "acts up" when approached by teacher or classmates. In reality this student's immature nervous system may be perceiving "touch" as a noxious stimulus and his or her only reaction is to pull away. This student could benefit from a gentle understanding of his or her problem as well as a remedial program to help normalize his or her sensory system.

4. The results of an immature nervous system may also be seen in delayed reflex maturation, particularly while in the hands and knees position. Every person, normal or impaired, has residual reflexes which can be elicited under stress. In the student with central nervous system problems, however, the reactions are generally exaggerated, occur each time you attempt to elicit them, and cannot be controlled by the individual. The fact that a student's arm bends while in hands and knees position when looking to the side is not in and of itself significant. What is important is the fact that this reaction points to an impaired central nervous system. This problem may express itself educationally in perceptual deficits, poor eye-hand coordination, poor visual motor and fine motor skills, and lack of handedness. This could have a profound effect on the student's success in classroom activities. A program to help improve the integration of the central nervous system would be a prerequisite or corequisite to working on the end product, such as a fine motor skill.

5. If a student has difficulty imitating large movements, chances are the student may also have problems with language and cognitive development, since motor imitation is a precursor of these skills. Typically, large muscle development precedes that of the smaller muscles of the body, including those of the face and mouth, and should be emphasized.

6. Problems with crossing midline will have a direct effect on a student's classroom performance. They may show up as difficulty with left to right progression, chalkboard activities, or table work. A student with one side of the body stronger than the other may tend to exhibit this problem, particularly on the weaker side, which he or she may ignore. This difficulty may be thought of as being associated with a central nervous system deficit and so can be worked on from two angles, first, increasing central nervous system integration, and second, improving the ability to cross midline with simple activities such as reaching for an object. With the student who avoids using the weaker side of the body, an effort should be made to increase the strength and awareness of that side as well as to encourage its use.

7. The efficiency of a student's grasp will have a direct effect on his or her fine motor ability. Many students cannot differentiate the small muscles of the hand from the larger ones of the arm and trunk. They are also unable to grade the use of these muscles. The result is a very tense grasp, with the student spending more time concentrating on how to hold on to the pencil than on the actual task. In addition, students who have poor shoulder stability may also have difficulty with grasp; the shoulder muscles provide the stability, and strong shoulder muscles are generally prerequisite for good hand use. Good muscle strength of the upper extremities, as well as differentiated use of each part, contributes to success in fine motor tasks.

8. Scoliosis, or curvature of the spine, may be a serious, sometimes life-threatening condition which is often correctable if caught early enough. It not only affects posture but has a significant effect on breathing and lung capacity. Any student suspected of having a scoliosis should be referred to the appropriate medical personnel.

9. If you suspect a student of having problems after this screening, help can be found through the adaptive physical education teacher, occupational therapist, or physical therapist. After further evaluation, they may choose to work individually with the student or give you suggestions for exercises to be carried out in the classroom. In either case, you will be making a significant contribution to the student's educational program as well as improving his or her motor abilities.

Instructions
Physical Function Screening for Non-Ambulatory Pupils

This screening tool is designed to assist in identifying those pupils who may need referral for additional evaluation by a physical or occupational therapist. It is not a skills inventory for the area of gross motor but is a method for identifying possible postural deformities, orthopedic problems, and central nervous system deficits. It is not intended as a diagnostic instrument or as a replacement for more in-depth physical and occupational therapy evaluations.

Materials

1. various toys for young child
2. mat or blanket to place on floor
3. two sets of screening forms, one for screener and one for recorder
4. pencils

Screening Team

The screening team includes a screener and a recorder.

1. The *screener:*
   a) directs pupil in appropriate activity
   b) observes responses
   c) instructs recorder

2. The *recorder:*
   a) records data according to screener's observations
   b) records pupil's behaviors

Setup

Administer the screening in a quiet room that is free from as many distractions as possible. A mat or non-allergenic blanket should be placed on the floor for both comfort and hygiene. If the pupil is a young child with bulky clothing, you may want to remove some of the outer clothing with the parent's permission. In addition, make sure there are no drafts near the area you will use.

Administration and Scoring

The sequence for administering the first part of the screening is as follows:

1. For the pupil who is unable to or will not follow directions:

   a) Observe the pupil's movements and record any items passed. Toys and verbal encouragement may be used to stimulate interest and movement.

   b) Assist the pupil with those movements or positions you have not observed, e.g., to encourage rolling you might partially turn the child from his or her back to the side by moving the hips. Wait and observe and record any responses.

   c) Finally, place the child in the positions that you feel may be within his or her capability but which have not been attempted. Withdraw your assistance gradually and observe if pupil can maintain the position or will make any compensating movements.

2. For the pupil who can and will follow directions:

   a) Ask the student to assume and maintain the listed positions. Record those accomplished independently.

   b) Assist the student with assuming those positions that could not be attained independently and record those results.

The second part of the screening requires some therapeutic knowledge as well as some subjective opinions. If the screener does not feel comfortable in completing this part of the form, he or she should seek assistance from a physical or occupational therapist. This will help provide a more thorough picture of the pupil as well as assist the screener in acquiring new skills.

NOTE:

- Children should always be handled gently but firmly and moved slowly. A child will sense any lack of security on the screener's part and may become anxious. Quick movements may be overstimulating to some children and cause them to be uncomfortable. It is also important to make sure that if you are assisting a child with a movement, you allow him or her to actively move as much as possible and allow sufficient time for the child to respond.

- Never put a child in a precarious position without maintaining close contact. If you have placed the pupil in a position and are gradually withdrawing your support, do not continue to do so if the pupil is frightened or unable to hold self up. The safety and well-being of the pupil is most important.

38

Pupil _____ Date _____
D.O.B. _____ Screened by _____
Center _____
Homeroom Teacher _____ Diagnosis _____

Physical Function Screening for Non-Ambulatory Students

For the following items, please check those columns which apply:

	Assumes independently	Assumes with minimum to moderate assistance	Needs total assistance to assume	Maintains independently	Maintains with minimum to moderate assistance	Needs total assistance to maintain
Lies prone on elbows						
Lies prone on extended arms						
Rolls from stomach to back						
Rolls from back to stomach						
Tailor sits						
Side sits						
Long sits						
Crawls on abdomen						
Hands and knees position						
Creeps on hands and knees						
Kneels						
½ Kneels						
Stands						

Cruises: ☐ Yes ☐ No
Walks with hand held: ☐ Yes ☐ No

Pupil can accomplish screening items on request: ☐ Yes ☐ No

Screener has observed pupil performing items, but pupil does not do so on request: ☐ Yes ☐ No

Head control
☐ Good
☐ Fair
☐ Poor

Current adaptive equipment:

Joint contractures
☐ Yes ☐ No
Describe:

Spinal or other obvious deformities
☐ Yes ☐ No
Describe:

Suggested modifications:

Muscle tone
☐ Within normal limits
☐ Too high
☐ Too low
☐ Fluctuating

Educational implications:

Primitive reflexes
☐ Yes ☐ No
Describe:

Grasp
☐ Functional
☐ Non-functional
Preferred hand: ☐ Left ☐ Right

Comments:

Sensation
☐ Within normal limits
☐ Hypersensitive
☐ Hyposensitive

Educational Implications

It is assumed that all students being administered this screening will have significant physical impairments. These students will probably be receiving input from a physical and/or occupational therapist—either directly or indirectly. It is important for the classroom teacher to work closely with these other professionals in order to provide the most appropriate program for each student. This cooperative teamwork can also be viewed as a learning experience for the teacher, who will become familiar with some of the more technical aspects of the screening.

For some of the students, particularly the younger, more severely involved ones, a large percentage of the day may be spent on gross motor activities; good motor skills are prerequisite for learning skills in other areas. For example, exploration of the environment is an important learning experience and is difficult to accomplish without good gross motor skills. The large muscles of the trunk and shoulder need to be functioning to provide stability before the hand can be used for manipulative activities. The muscles of the trunk and neck need to hold the head steady before eyes and mouth can function well. Motor skills are essential for socialization with peers. As a result, teachers should not feel guilty about spending so much time on motor activities because they will be enhancing skill achievement in other areas as well.

Another important aspect in working with physically involved students is positioning and adaptive equipment. Proper positioning can help prevent deformities and pressure sores. In addition, positioning and adaptive equipment can help improve the student's ability in other areas. Language may be enhanced through better upright positioning; feeding is definitely made easier; manipulative skills are improved; the student may be stimulated and made more aware through change of positions; head control may be increased; breathing will be made more efficient. An occupational or physical therapist will usually be able to help the classroom teacher with positioning and equipment goals.

The classroom teacher also needs to have some medical information about his or her students. For example, if a student has had recent surgery on his or her legs, what kinds of things should the teacher be doing and what should be avoided? If the teacher knows a little about the prognosis of a student (will he or she improve? regress? walk?), the teacher will be better able to plan the classroom program. Knowing about the severity of the student's handicaps will also help the classroom teacher plan how much assistance will be needed in the classroom.

Keeping all this in mind, one can see why it is essential for the classroom teacher to realize the importance of improving motor skills in physically involved students and having thorough working knowledge of motor development. Towards this end, an occupational or physical therapist can be extremely helpful in assisting the teacher. Teamwork works both ways, however, and this is an excellent opportunity for educators to help medically oriented personnel learn about the educational approach to their students. A well-balanced, understanding team will work most efficiently toward developing good student programs.

ORAL MOTOR

43

Instructions for Oral Motor Screening

This screening is designed to be administered by a therapist (occupational, physical, or speech) in conjunction with the classroom teacher. If the screening is to be used as part of an intake procedure, the pupil's parents can be an invaluable source of information about his or her eating skills. The data collected during the screening will enable the screener to determine the most effective placement of the pupil in the lunchtime program. Oral motor dysfunction, adaptive equipment requirements, and need for further evaluation can be ascertained.

Materials

1. tongue depressors
2. spoons (regular and Teflon-coated)
3. applesauce
4. crackers
5. paper cups (small size)
6. paper towels
7. bowl
8. sticky pad

Screening Team

The screening team includes a screener and a recorder.

1. The *screener:*
   a) introduces food or utensils to pupil or directs pupil in appropriate activity
   b) observes responses
   c) instructs recorder

2. The *recorder:*
   a) records data as observed by screener
   b) records behaviors which might influence success during lunchtime

Setup

It can be determined during the course of the Physical Function and Cognitive Screenings whether the pupil is a self-feeder (Levels I and II) or whether he or she requires some or total assistance at lunchtime (Levels III and IV). See accompanying matrix.

Procedure

A. *Positioning and/or Adapted Equipment*—A description of the student's current wheelchair and/or special equipment used during lunchtime.

B. *Oral Sensory Function*

C. *Oral Motor Function*

For Levels I and II, items B (Oral Sensory Function) and C (Oral Motor Function) can be observed as student eats a variety of textures, and drinks from a cup. For Levels III and IV, items B and C can be observed as screener offers pupil a variety of textures with different types of utensils using varing amounts of physical assistance. If a parent is present, the answers to unresolved screening items can be obtained. It may be necessary to write a note home on the student's first day of school if a parent is not present during the screening.

For those students functioning on Levels I and II (see accompanying matrix), the following equipment is needed:

1. bowl with applesauce
2. sticky pad
3. crackers
4. spoon
5. paper cup with liquid
6. napkin or paper towel

For those students functioning on Levels III and IV (see accompanying matrix), the following equipment is needed:

1. bowl with applesauce
2. two types of spoons (regular and Teflon-coated)
3. paper cups with "nose hole" torn out of side, half filled with water or juice
4. crackers
5. paper towels to protect pupil's clothing

Strategies

For the ambulatory student, note should be made of the size and type of chair most suitable for lunchtime use. If the student is physically involved, the fact that he or she requires an adapted chair must be recorded and described under Section A. If changes in or additions to the seating arrangement are deemed necessary following the Oral Motor Screening, please describe these fully under Section D (Adaptive Equipment).

Food preferences, textures accepted, behavior management techniques, can be determined by conversation with the parents if they are present for an intake or initial IEP conference. If parents are not present, observation during the pupil's first days at school and/or a note home may be necessary to complete the screening.

Evaluation

Data collected during the screening will determine to which of four functional levels the student belongs. See the accompanying matrix for a full description of the four functional levels.

If a pupil is described as Level I or II, the classroom teacher can complete the short lunchtime program assessment which is printed on a 5"x 8" file card.

Pupils described as Level III or IV will require further evaluation by the appropriate therapist, who will then complete the long lunchtime evaluation form.

Eating Skills/Grouping of Students by Functional Level

Kilmer Center/Project APT

Level	Physical Function	Positioning	Adaptive Equipment	Food Preparation	Strategies
I	Has functional oral motor skills ... ranges from child who has just started independent eating to child who requires minimum attention but is working on social skills. Drinks from cup or uses straw.	Comfortable chair of appropriate size: hips back in seat, knees flexed and feet flat on floor. When child is seated, elbows should rest comfortably on table.	May range from special dish and spoon on Dycem mat to regular cafeteria tray and utensils.	May range from food cut up in bite-size pieces to little or no preparation of normal serving.	May range from verbal prompt with occasional physical assistance to verbal prompt with minimal physical assistance.
II	Oral motor skills are functional. Has good sitting balance, but has minimal self-feeding skills. Drinks from cup. May be learning to use straw.	Comfortable chair of appropriate size: hips back in seat, knees flexed and feet flat on floor. When child is seated, elbows should rest comfortably on table.	May use an adapted cup with "nose hole" for drinking, adapted dish and spoon, Dycem mat for stability.	Food may require cutting up or may be mashed with fork.	Needs assistance with self-feeding. Ranges from total physical assistance (modeling) to physical assistance with running commentary, gradually fading to verbal prompt.
III	Moderately physically involved child. Has functional oral motor skills. Hand function is minimal. Has poor sitting balance. Chews food, but may have problems with drinking.	Adaptive seating equipment; must be carefully positioned for optimum results.	Teflon-coated spoon. May require special drinking cup with "nose hole."	Food requires mashing with fork or grinding in some cases. Liquid may be added to achieve appropriate consistency.	Food must be placed in mouth. Cup must be held for drinking. Feeder can monitor another child "in-between bites." Milk swallowed three-four sips at a time.
IV	Severely physically involved child who has minimal oral motor skills. Drinking is very difficult so that fluid intake is a major concern. Requires careful positioning and total assistance at meal time.	Adaptive seating equipment; must be carefully positioned for optimum results. In some instances, relaxation exercises or oral stimulation ½ hour before lunch contribute to better oral motor control at lunch.	Teflon-coated spoon. May require special drinking cup with "nose hole."	Food requires grinding with additional liquid added for appropriate consistency.	Food must be carefully placed in mouth with feeder's preferred hand. Other hand is used for jaw control in varying degrees. Milk swallowed two-three sips at a time.

Pupil _____ Homeroom Teacher _____
D.O.B. _____ Date _____
Center _____ Screened by _____

Oral Motor Screening

Diagnosis:

A. Positioning and/or Adapted Equipment (currently in use):

B. Oral Sensory Function

1. Internal
   - ☐ gags upon introduction of solid foods
   - ☐ refuses textured foods
   - ☐ within normal limits
2. External
   - ☐ actively resists touch of hand or washcloth around mouth
   - ☐ becomes irritable when touched on cheeks
   - ☐ within normal limits

C. Oral Motor Function

1. Lip Closure
   - ☐ loses food
   - ☐ lips close around spoon
   - ☐ functional
2. Tongue Function
   - ☐ tongue thrust
   - ☐ gag reflex
   - ☐ lateralization
   - ☐ elevation
   - ☐ functional
3. Biting
   - ☐ tonic
   - ☐ phasic
4. Drinking
   - ☐ suckles
   - ☐ sucks
   - ☐ swallows
   - ☐ uses cup
   - ☐ uses straw
   - ☐ functional
5. Chewing
   - ☐ tongues food
   - ☐ munches
   - ☐ rotary chewing
   - ☐ functional

D. Suggestions for Optimal Feeding

1. Environment:

2. Adaptive Equipment:

3. Adaptive Utensils:

4. Food Preparation:

5. Strategies:
   a) physical

   b) behavioral (management techniques):

E. Evaluation

1. Educational implication:

2. Functional level:

3. Appropriate feeding form: ☐ long ☐ short

49

Lunchtime Program Evaluation
Levels I and II

Pupil _____

Seating Arrangements
Type of chair _____
Adaptations _____
Restraints _____

Food
School lunch:
Regular ___ Chopped ___ Ground ___
Home lunch_____
NVTC lunch_____

Disposal of
Paper_____
Utensils _____
Food _____
Plate _____
Tray _____

Beverage
Milk _____
Water _____
Juice _____

Container
Carton _____
Paper Cup _____
Tumbler _____

Method
Uses straw _____
Holds Own Cup ___
Needs Cup Held___

Room No._____
Date _____
Amount of Time Needed _____

Special Preparations _____
_____

Utensils and Adaptive Equipment
Spoon _____
Fork _____
Knife _____
Napkin _____
Bib_____
Other (Specify) _____
_____

Serving and Clearing
Carries own plate _____
Carries plate on tray_____

Kind and Amount of Assistance Needed
(Describe special feeding techniques) _____
_____
_____
_____

(over)

Side 1

Special Problems
(behavior management, allergies, special precautions, strong likes, strong dislikes)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Goals _____
_____
_____
_____
_____
_____

Date *Assigned Staff Member* *Comments*

_____
_____
_____
_____
_____

50

Side 2

Lunchtime Program Evaluation
Levels III and IV

Pupil		D.O.B.	
Date	Current Level of Functioning:		
Date	Current Long Range Goal:		
Date	Monitor:	Consultants:	
Date	Current Behavioral Objectives	Evaluation	Date

51

Original Instructional Plan for _____ Date _____

A. Environmental

B. Materials

C. Strategies
1. Physical

2. Behavioral

52

Educational Implications

Students who are identified as having oral motor problems as a result of this screening are best served by the attached long feeding form, which is further described in Project APT's "Mealtime Management" packet.

Teachers should make use of all possible resources in order to develop an effective oral motor program for each student. The occupational and/or speech therapist can fill out the enclosed long feeding form after a full evaluation is completed. The family dentist is an important member of this interdisciplinary team. Many chewing and swallowing difficulties can be attributed to dental caries, missing teeth, or periodontal problems. It follows that classroom emphasis on good oral hygiene and good nutrition is important and appropriate.

The mouthing of toys and objects is a primary learning channel for many low-functioning students, and the teacher must constantly remember not to discourage this as it is an appropriate activity for pupils at this developmental level.

The teacher planning a schedule for low-functioning pupils with oral motor deficits must realize that one or two hours spent on oral stimulation, eating, and tooth brushing is, indeed, a valid use of classroom time.

Oral motor goals and objectives help to make the pupil more socially acceptable and can help to ease the parents' role during mealtime at home and can contribute to a more efficient use of staff at school and in a residential unit.

Teachers and therapists must remain realistic about progress in the oral motor area. It is more reasonable to have a goal of mouth-wiping for the teenage chronic drooler with structural oral abnormalities than to expect a complete cessation of drooling. Maintaining or adapting to current level of functioning may be all that can rightfully be expected.

53

MALADAPTIVE BEHAVIOR

55

Instructions for Maladaptive Behavior Checklist

This screening tool is designed as the first step in gathering information to set up a consistent behavior management program at home and at school on inappropriate behaviors which require intervention.

It is divided into two major sections:

1. General Observations
2. Behavioral Checklists

Screening Team

Parents complete form reflecting home behavioral information. Teachers also complete Maladaptive Behavior Checklist from school observation.

Setup

The format for completing this checklist is done through observation both at home and at school. Teachers typically complete this screening during the first month of school. Parents are asked to complete the screening prior to the IEP conference.

Procedure

Observations: Parents and teachers record general observations, noting any previous behavior management programs and their effectiveness. Additionally, in this section, it is important to note any informal attempts to change behaviors that have been utilized in the past.

Behavioral Checklists: The four behavioral checklists, Aggressive/Destructive, Self-Abusive, Socially Inappropriate, Disruptive, each contain specific maladaptive behaviors to be checked as non-occurring or occurring at one of the approximate frequencies. These guesstimates of behavioral frequency are not intended to be precise or to offer formal baseline data, but rather to help in putting programming in priority order. In the far-right-hand column of each behavior listed, there is a box labeled "Request Consultation" to indicate the desire for an immediate conference to discuss the behavior. This conference is coordinated with the child's parents, teachers, and other appropriate resource personnel within the school.

Unless a special conference is requested, the Maladaptive Behavior Checklists, completed by both parents and teacher, are brought to the IEP meeting to share and compare home-school functioning. Looking at the total picture of the student's behavior provides a forum for candid discussion and a vehicle for initiating consistent behavior management programs.

Pupil _____ Date _____
D.O.B. _____ Completed by _____
Center _____ Teacher _____ Parent _____

Maladaptive Behavior Checklist

Screening Team
Separate forms completed yearly by both homeroom teacher and parents.

Scoring
Put a check under the column that most closely indicates the frequency of occurrence; also please consider and check under "Request Consultation" column if you feel behavior necessitates.

Observations
Please note any previous behavior management programs and their effectiveness:

_____

_____

_____

_____

_____

1. Aggressive/Destructive Behavior

	More than once a day	Daily	Weekly	Monthly	Non-Occurring	Request Consultation
Aggressive with peers						
Aggressive with adults						
Destructive with objects						
Tantrums						
Other (describe)						

2. Self-Abusive Behavior

	Constantly	Hourly	Daily	Weekly	Non-Occurring	Reques Consultation
Bangs head						
Bites, hits, scratches, etc., self						
Pulls out own hair						
Other (describe)						

3. Socially Inappropriate Behavior

	Constantly	Hourly	Daily	Weekly	Non-Occurring	Request Consultation
Wanders, runs away						
Smears feces; urinates inappropriately						
Masturbates publicly						
Removes clothing inappropriately						
Hugs, kisses, touches others inappropriately						
Burps, belches						
Talks loudly, uses coarse language						
Laughs, cries inappropriately						
Keeps hands full of string, objects						
Rocks, self-stimulates						
Is withdrawn, does not interact with others						
Other (describe)						

4. Disruptive Behavior

	Constantly	Hourly	Daily	Weekly	Non-Occurring	Request Consultation
Is extremely active						
Interferes with other's activities						
Perseverates						
Becomes upset if told "No"						
Refuses to take part in activities						
Does not follow classroom routine						
Other (describe)						

Educational Implications

Intervention for students identified through this screening as having significant behavior problems must, of course, be individualized to the student and the situation. Project APT's training packet, "Preventive Planning for Behavior Control", offers suggestions for environmental adaptation. In some instances, a behavior may be interfering to such a degree as to require a formal behavior management program to be implemented both at home and in school. This kind of program requires continual data keeping and careful monitoring. Priorities for developing behavior management programs are as follows:

1. dangerous behaviors to self or others
2. disruptive behaviors
3. inappropriate or annoying behaviors

The forms following this section are designed to allow all the persons coming in contact with a particular student to logically organize an appropriate behavior program.

Behavior Mangement Information

This card is completed by parents and teachers and serves as an ongoing consequence file. The front portion of the card can be filled out by parents and teachers together at the initial IEP conference and updated at subsequent conferences. The back of the card is simply a worksheet for teachers to use in listing and revising possible consequences.

Initial Behavior Management Program Worksheet

This form offers a format for a group discussion about an interfering behavior. The top section of the sheet gathers background data, and the lower section outlines the specific targeted behavior and the action to be taken.

Handling Orders Consent Form

Before a behavior management program can be implemented, it is necessary to formally outline any restrictive intervention plan that has been formulated and secure signatures from the parent, the program manager, and the staff psychologist. This system ensures that home and school are in agreement and well informed about the techniques that will be used, and that these strategies will receive a periodic review. This form applies only to more restrictive programs outlined in Levels 2 and 3 of the next section.

Levels of Intervention

The behavior management program developed for a student always uses the least restrictive intervention techniques that will effectively remediate the target behavior(s) of that particular student. Intervention strategies are grouped into three main categories designated as Levels 1, 2, 3 to reduce or eliminate maladaptive behaviors. Reinforcement strategies for building desired behaviors are always coupled with interventions used to remediate inappropriate behaviors.

Level I intervention involves techniques that are defined and approved by the classroom teacher. The techniques used at this level are the least restrictive available to the teacher for controlling classroom behaviors. Baseline data, written plans, and ongoing data collection are not required, and the techniques are available to all staff members. This level of intervention is the most commonly implemented with students.

Level 2 intervention requires the approval of the parent/guardian, psychologist, principal (or designee), and staff personnel, before implementation. Baseline data is recorded before the program begins to provide staff members with accurate information about the frequency and duration of the target behavior. Continuous record keeping is necessary to determine objectively whether selected techniques have been effective, e.g., has the behavior changed in the desired direction? A Level 2 program is put in writing with appropriate signatures and reviewed every 30 days by the staff and every 90 days by the psychologist.

Level 2 intervention is to be used only after Level 1 techniques have been tried and found either unsuccessful or insufficient. Safety belts, helmets, or other mechanical restraints used for safety reasons to prevent injury to the student are not included.

Level 3 intervention techniques require a written plan, baseline and ongoing frequency data, regular reviews (10-30 days), and the approval of the principal, psychologist, parent/guardian, and staff personnel. These techniques are to be used only after all viable procedures at Levels 1 and 2 have been tried and found unsuccessful or insufficient.

Examples of Intervention of Strategies for Reducing Interfering Behaviors

Strategy	*Approval Required*	*Agent*
Level 1		
Admonishing	Classroom teacher	All staff
Visually		
Verbally		
By proximity		
By touch		
Planned ignoring (extinction)		
Excluding (from group or activity)		
Verbally		
Physically		
Removal of reinforcers		
Losing turn		
Losing material or free-time activity		
Time out without restraints		
In room		
In hall		
Redirecting		
Distracting		
Shortening task requirement		
Simplifying task requirement		
Modifying classroom environment		
Correction		
Shaping		
Level 2		
Restraining*	Parent, Psychologist, Principal, Administrative Assistant	Specialists, Teachers, Aides
In chair		
In room		
In hall		
Special clothing		
Gloves		
Over-correction		
Autism reversal		
Level 3		
Time out room	Parent, Psychologist, Principal, Administrative Assistant	Specialists, Teachers, Aides
Physical restraints		
Elbow restraints		
Other aversive techniques		

* Not included are restraints used for safety purposes

The educational implications of this screening are self-evident; serious interfering behaviors are obvious impediments to effective learning. It is hoped that the information included will offer a system for remediation.

Behavior Management Information

Pupil:
D.O.B.:

Date:
Completed by:

Positive Consequences

Primary (edibles, toys, objects):

Tokens (charts, stars, coins):

Activities:

Social:

Negative Consequences

Verbal:

Withholding:

Isolation:

Comments:

Side 1

Date:	Date:	Date:	Date:
Positive:	Positive:	Positive:	Positive:
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
Negative:	Negative:	Negative:	Negative:
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
Teacher:	Teacher:	Teacher:	Teacher:

Side 2

Initial Behavior Management Program Worksheet

Pupil _____ Date _____

Behaviors of immediate concern: _____

Student's likes: _____

Student's dislikes: _____

How long behaviors noted (years?): _____

What has been tried before? _____

Notes: _____

Target behaviors: _____

Action to be taken: _____

Next meeting date: _____

Behavior Management Program: Handling Orders Consent Form

Pupil _____ Date _____
D.O.B. _____ Center _____

Target Behaviors/Handling Orders:

The school psychologist has read the above handling orders and finds they are appropriate in light of the child's present level of functioning.

The staff will review these handling orders every _____ days, and the school psychologist will review them every _____ days to determine if they continue to be appropriate.

Parent Signature	Date	Psychologist	Date	Staff Signature	Date
Principal	Date	B.M.P. Coordinator	Date	Staff Signature	Date

Review Dates

Date	Initials	Date	Initials	Date	Initials
Date	Initials	Date	Initials	Date	Initials
Date	Initials	Date	Initials	Date	Initials

COGNITION CHECKLIST

65

Instructions for Cognition Checklist

This checklist is designed to be administered by the classroom teacher. It attempts to provide a quick educational assessment for program planning and initial IEP development

All items through the 6 year level have been taken from the Developmental Achievement Wheel. The reference for each item is listed in parentheses and is as follows:

1. Letter corresponds to the specific developmental area, i.e., FM = Fine Motor, R = Receptive Communication.

2. Number corresponds to the specific developmental milestone listed within the sequence.

Materials

squeak toy
action toy — Hippo Toy
puppet
blocks
nesting boxes
scarf
3 boxes same size
crayons
unlined paper
combs (2)
spoons (2)
toothbrushes (2)
pencil
cup
picture book
numeral cards
toy cars
baby doll and bottle
pull toys
rattle
dress-up hats, rings, jewelry
flannel board letters

Administration

Most of the items on the Cognition Checklist were designed to be observed in a natural play setting. The list of materials offers suggestions for evoking desired responses. The observed responses will help the teacher determine the child's functional level. The results of the Cognition Checklist can be transferred to the Developmental Achievement Wheel giving the teacher a headstart on the more complete educational assessment.

Scoring

The scoring of the Cognition Checklist is fairly straightforward—simply place a check in the appropriate column.

During your observation of the child's play and interaction, note and record the receptive and expressive mode of communication and preferred hand use requested at the end of the form.

Pupil _____
D.O.B. _____
Center _____

Homeroom Teacher _____
Date _____
Screened by _____
_____
_____

Cognition Checklist

Yes	No	
		0 - 6 Months
		Looks directly at object—prolonged fixation (FM-1).
		Reacts to sounds in environment by increasing or decreasing body movements (R-1).
		Keeps hands open—plays with them and looks at them (FM-3).
		Looks in direction of fallen object (C-1).
		6 Months - 1 Year
		Tries for object out of reach (C-3).
		Puts toy in mouth (FM-9).
		Bangs toy up and down (FM-12).
		Bangs two toys together (FM-14).
		Rings a bell or squeezes a toy (FM-18).
		Takes toy out of box or cup (C-6).
		Attempts to uncover partially hidden object (C-4).
		1 - 2 Years
		Looks at pictures in a book (C-7).
		Correctly chooses proper name when offered 2 alternatives for body part (C-10).
		Imitates putting object in a box (C-8).
		Finds object hidden under 1 of 3 boxes on first trial (C-11).
		1 - 6 Years
		Builds a two object tower (FM-23).
		Builds a four object tower (FM-30).
		Builds a tower of six 1" cubes (FM-35).
		Builds a tower of eight 1" cubes (FM-40).
		Builds a tower of ten 1" cubes (FM-43).
		Imitates train with three 1" cubes (FM-34).
		Imitates bridge with three 1" cubes (FM-46).
		Scribbles with crayon on paper spontaneously (FM-28).

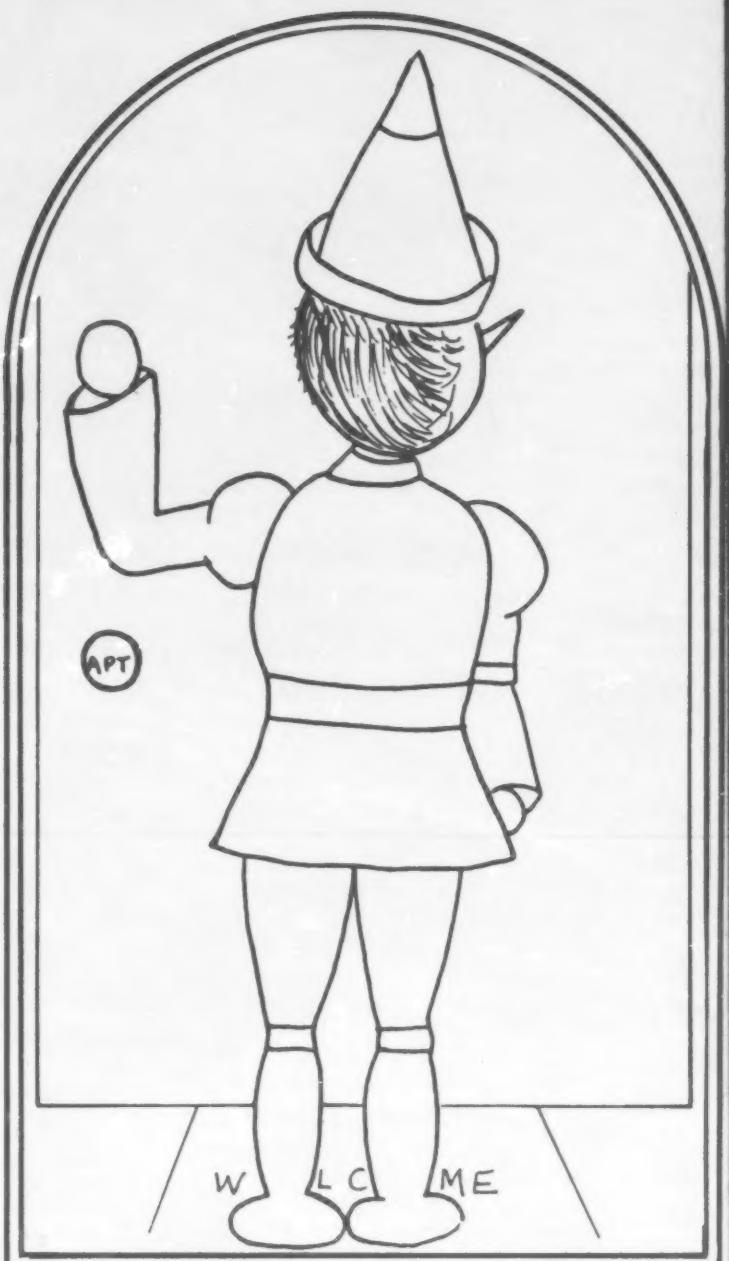
Yes	No	
		Imitates vertical and circular strokes on paper (FM-33).
		Imitates horizontal stroke on paper (FM-41).
		Imitates cross (FM-45).
		Imitates square (FM-52).
		Draws a person with 3 parts (FM-60).
		Draws a person with 6 parts (FM-66).
		2 - 4 Years
		Gives two blocks to screener when requested (C-14).
		Matches 3 familiar objects to 3 like objects (C-15).
		Associates use with 4 familiar objects (C-16).
		Attends to simple stories read from picture book or flannel board (C-17).
		Can then identify three pictures in story above.
		4 - 6 Years
		Points to 4 colors by name (C-19).
		Demonstrates concept of size by assembling nesting boxes (C-22).
		Imitates tapping by screener—5, 2, and 4 taps (R-24).
		Knows left from right (C-25).
		Recognizes numerals 1-10 (C-26).
		6 - 8 Years
		Matches letters visually.
		Matches words auditorily.
		Names letters.
		Makes simple words from flannel board letters.
		Follows 3 part verbal directions.
		Prints own name.
		Copies two designs:

Communication Mode

Receptive
- ☐ Auditory
- ☐ Gesture
- ☐ Sign
- ☐ Communication Board

Expressive
- ☐ Speech
- ☐ Gesture
- ☐ Sign
- ☐ Communication Board

Preferred hand use: ☐ Left ☐ Right



HOME INFORMATION

Instructions for Home Information Questionnaire

The Home Information Questionnaire was designed to gather current home functioning data from a new student's parents. Based on the philosophy that a parent knows the child best, this form requests family information that will help to make a new student's first days meaningful and pleasant. It also offers the teacher a baseline for program planning. It is suggested that this sheet be mailed to parents so that the completed form can be brought with the student to the initial intake conference.

There are two versions of this questionnaire—Form A, designed for the younger or lower-functioning student, and Form B, for the older, or higher-functioning student. Pages 1 and 2 of these forms are identical. Page 3 of each form focuses on those abilities and skills which are tailored to age difference and functioning level.

After the packet of information on the new student has been reviewed, it is relatively easy to determine which form would be most appropriate for an individual student.

Form A

Home Information

Date _____

Pupil _____
First Middle Last Nickname

D.O.B. _____
Center _____

A. Medical Information

1. What have doctors told you about your child's diagnosis? _____
_____

2. Does your child have any other continuing medical problems (seizures, chronic ear infections, allergies, elimination difficulties)? _____
_____

3. Please list your child's present doctor and any specialists he or she may have seen in the past (use back if necessary):

Doctor/Dentist Date last seen

_____
_____
_____
_____
_____

4. Please describe current and past medical treatment: _____
_____
_____

Surgery: _____
_____
_____

Medication: _____
_____
_____

Date medication last reviewed _____

5. Are there any medical restrictions on your child's activities? If so, please specify: _____
_____
_____

B. Family Information

1. Who lives in the home? (If child calls person special name, please list)

Siblings (in order of age)
_____
_____
_____
_____

Mother _____
Father _____
Grandparents _____
_____
Other _____

2. With whom does your child have a special relationship? _____

3. How do you reward your child when you are pleased with him or her? _____

4. What do you do if your child misbehaves? _____

5. (a) How does your child communicate his or her needs? _____

(b) How do you communicate with your child? _____

6. Describe briefly a typical day for your child including: when child gets up and goes to bed, rest time, mealtimes and snacks, leisure activities, household chores child helps with, etc.: _____

7. Is your child involved in activities outside the home? (please check)

- ☐ Church
- ☐ Scouts
- ☐ Recreation program
- ☐ Community activities
- ☐ Summer camp
- ☐ Family outings
- ☐ Special Olympics
- ☐ Other (describe) _____

Does your child play well with siblings? _____

Does your child play well with other children? _____

8. What are your child's favorite toys or games? _____

C. Classroom Considerations

Does your child:

	Yes	No
Object to being touched or held?	____	____
Avoid certain textures of food?	____	____
Seem overly sensitive to sound?	____	____
Seem easily distracted by noise?	____	____
Appear sensitive to light?	____	____
Become excited when confronted with a variety of visual stimuli?	____	____
Seem fearful in space, e.g., going up and down stairs, riding teeter totter?	____	____
Appear clumsy, often bumping into things and/or falling down?	____	____

D. Daily Living Skills

1. Dressing/Undressing
   (a) Does your child undress himself or herself and are there any problems? _____
   _____
   (b) Does your child dress himself or herself and are there any problems? _____
   _____

2. Toilet training
   (a) Is your child trained to go to the bathroom by himself or herself? _____
   (b) How does he or she communicate his need? _____
   (c) What is his or her toileting schedule? _____
   (d) Are there any problems we should know about? _____
   _____
   _____

3. Eating

   Does your child:

	Yes	No
Eat table foods?	____	____
Eat specially prepared food?	____	____
Chew bites adequately?	____	____
Feed self?	____	____
Drink from a cup?	____	____
Hold own cup?	____	____
Drink from a straw?	____	____

Circle the utensils your child uses: spoon, fork, knife, adapted spoon/fork.

Circle hand your child primarily uses: left, right.

Please describe any special techniques and/or concerns or problems you have associated with mealtime. _____
_____
_____

E. Parent Concerns

What are your major concerns at this time? _____
_____
_____

How can we help you? _____
_____
_____

What do you hope this school can do for your child? _____
_____
_____

_____
Signature

_____
Relationship to child

Form B

Home Information

Date _____

Pupil _____
First Middle Last Nickname

D.O.B. _____
Center _____

A. Medical Information

1. What have doctors told you about your child's diagnosis? _____
_____

2. Does your child have any other continuing medical problems (seizures, chronic ear infections, allergies, elimination difficulties)? _____
_____

3. Please list your child's present doctor and any specialists he or she may have seen in the past (use back if necessary):

Doctor/Dentist Date last seen

_____
_____
_____
_____
_____

4. Please describe current and past medical treatment: _____
_____
_____

Surgery: _____
_____
_____

Medication: _____
_____
_____

Date medication last reviewed _____

5. Are there any medical restrictions on your child's activities? If so, please specify: _____
_____
_____

B. Family Information

1. Who lives in the home? (If child calls person special name, please list)

Siblings (in order of age)
_____
_____
_____
_____

Mother _____
Father _____
Grandparents _____
_____
Other _____

2. With whom does your child have a special relationship? _____

3. How do you reward your child when you are pleased with him or her? _____

4. What do you do if your child misbehaves? _____

5. (a) How does your child communicate his or her needs? _____

(b) How do you communicate with your child? _____

6. Describe briefly a typical day for your child including: when child gets up and goes to bed, rest time, mealtimes and snacks, leisure activities, household chores child helps with, etc.: _____

7. Is your child involved in activities outside the home? (please check)

- ☐ Church
- ☐ Scouts
- ☐ Recreation program
- ☐ Community activities
- ☐ Summer camp
- ☐ Family outings
- ☐ Special Olympics
- ☐ Other (describe) _____

Does your child play well with siblings? _____

Does your child play well with other children? _____

8. What are your child's favorite toys or games? _____

C. Classroom Considerations

Does your child:

	Yes	No
Object to being touched or held?	_____	_____
Avoid certain textures of food?	_____	_____
Seem overly sensitive to sound?	_____	_____
Seem easily distracted by noise?	_____	_____
Appear sensitive to light?	_____	_____
Become excited when confronted with a variety of visual stimuli?	_____	_____
Seem fearful in space, e.g., going up and down stairs, riding teeter totter?	_____	_____
Appear clumsy, often bumping into things and/or falling down?	_____	_____

D. Daily Living Skills

1. Dressing/Undressing
   (a) Is your son or daughter independent in dressing and undressing? _____
   (b) Are there any additional skills you would like your son or daughter to acquire in this area? ____
   _____
   _____

2. Grooming/Toileting
   (a) Can your son or daughter take care of all of his or her grooming and toileting needs? _____
   (b) Are there any additional skills you would like your son or daughter to acquire in this area? ____
   _____
   _____

3. Eating
   (a) Does your son or daughter require any adaptive equipment for eating? _____
   (b) Circle the utensils your son or daughter uses: spoon, fork, knife.
   (c) Does he or she display appropriate table manners? _____
   (d) Are there any additional skills you would like your son or daughter to acquire in this area? ____
   _____
   _____

4. Housekeeping skills
   (a) What kinds of housekeeping chores does your son or daughter regularly perform, e.g., food preparation, cleaning, yard work? _____
   _____
   (b) Does he or she receive any allowance for these chores? _____
   (c) Does your son or daughter (or did he or she in the past) have a job outside of the home for which he or she was paid? _____

5. Independence and responsibility
   (a) Do you allow your son or daughter to remain at home alone? _____
   (b) Does your son or daughter run errands outside the home? _____
   _____

E. Parent Concerns

What are your major concerns at this time? _____
_____
_____

How can we help you? _____
_____
_____

What do you hope this school can do for your child? _____
_____
_____
_____
_____

_____
Signature

_____
Relationship to child